Facilitating Visitation for Infants with Prenatal Substance Exposure

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Abstract (Summary)
Permanency planning for infants with prenatal substance exposure is challenging due to characteristics of the infants and the ongoing substance use or relapse of the parents. Visitation is a primary mechanism through which child welfare workers determine and support permanency planning. Productive use of visitation for permanency planning for infants with prenatal substance exposure is described, along with strategies for skillfully focusing visits on issues and needs relevant to this population. [PUBLICATION ABSTRACT]

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During the past two decades, the number of children coming into foster care due to prenatal substance exposure (PSE) has increased dramatically. Permanency planning for these children is challenging both because of the effects of exposure on the children and because their birthmothers are likely still using drugs at the time of the children's placements. In addition, the Adoption and Safe Families Act of 1997 (ASFA), which shortens timelines for permanency planning, adds to the challenge because short-term treatment of the mother may not result in the changed lifestyle needed for creating a safe and stable home for the child.

The primary child welfare practice strategy for both decisionmaking for permanency and achieving the plan is visitation. This service, often neither fully understood nor fully used by practitioners, is increasingly important in light of problems and issues associated with PSE children. This article addresses the use of visitation as a child welfare intervention when a child with PSE is in out-of-home care, and discusses special issues in providing such intervention.

Definitions

Visitation is planned, face-to-face contact between a child (or children) in out-of-home care and the birth family (or created family, as through adoption), apart from family counseling (Chiancone, 1997). Loar (1998) called it the key to successful reunification, and Hess and Proch (1993) described it as the heart of reunification services. Visitation is

the primary mechanism through which family relationships are maintained while a child is in care-permanency decisions are made and work toward achieving the permanency goal is undertaken.

Current thinking regarding visitation expands our understanding of this service. An ecological perspective reminds us that children in care are separated from more than their parents (Oysterman & Benbenishi, 1992). They are also separated from other people, such as siblings, other relatives, or friends; from organizations, such as school and church; and from places including their own room, the park, the corner drug store, and a favorite fast-food restaurant. Thus, visitation, as fully understood, includes keeping children connected to a range of significant people, associations, and places.

Planning, facilitating, and monitoring visitation involves a team approach in which a many professionals and nonprofessionals with defined roles work together toward the case goal. This is particularly important when the child involved has significant medical, psychological, or social problems. Thus, the team may include not only the core participants-the parent, child, foster parents, and caseworker-and other important people from the child's life, but also a range of service providers.

This article focuses on visitation between a special population of children and their caregivers. These are infants with PSE-children from birth to age 2 who have had prenatal exposure to drugs, alcohol, or other medications beyond what was prescribed. Most of these infants will have had exposure to more than one of these substances. Usually, their parents continue to have significant substance abuse problems when the children enter care.

Background and Prevalence

Despite efforts over the past two decades to reduce our population of children in foster care, an estimated 547,000 children in the United States were in foster care on March 31, 1999, according to the AFCARS Report (U.S. Department of Health and Human Services [DHHS], 2000). Most of these children were living in nonrelative foster family care (47% or 259,815), and 27% (or 145,789) were living in relative foster family care. Their average time in care was 22 months.

Although more children entered care than exited (119,000 versus 102,000) between March 1,1999 and October 1,1999, this difference was particularly pronounced with children younger than 1. In that group, 13% (15,490) entered care, but only 4% (4,121) left care, indicating that the proportion of younger children in care is increasing.

The AFCARS Report (DHHS, 2000) does not supply information related to PSE or other child disabilities because of the unreliability of that information. The National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families (DHHS, 1997), however, provides data that may be informative. The report, which covers the period February 24, 1984 through March 1,1993, relates child characteristics to length of time in the child welfare system. It shows children entering

the system between birth and age 3 are more apt (55%) to stay longer (cases opened 18 months or longer), as are children with disabilities (55%).

Thus, from these two national data sources we may conclude that the population of concern to this article-children ages O through 2 with PSE-are part of a group that is increasingly represented in the foster care population.

Other information is available specifically about the PSE population in care. The prevalence rate of all newborns testing positive for drugs or alcohol at birth is from 10% to 15%, which means up to 400,000 babies are born with PSE annually (Christensen, 1997; Substance Abuse and Mental Health Services Administration, 1993). When birthmothers use substances during pregnancy, their infants with PSE will likely be placed in foster care (Groze, HainesSimeon, & Barth, 1994; Wasserman & Leventhal, 1993). Ninety percent of counties that have been surveyed reported receiving referrals of infants with PSE (Ondersma, Malcoe, & Simpson, 2001). In fact, as many as 80% of all child protective services cases involve substance use by birthparents (Rogers & McMillin, 2000).

Purpose and Benefits of Visitation

When children are in out-of-home care, visitation is a critical child welfare service. Although it is sometimes associated with preparing families for reunification, it is equally important regardless of the permanency plan (Hess & Proch, 1993). This section reviews the general purpose and broad benefits of visitation as background for the discussion of special issues related to infants with PSE.

The purpose of visitation is to promote desired child welfare services outcomes as supported by ASFA and addressed by monitoring activities of the Child and Family Services (CFS) review: safety, permanence, and well-being. In addition, visitation can increase the likelihood of reunification-usually the preferred permanency plan if it is consistent with child safety-and to reduce the length of time in care (Hess, 1999, 2005; Loar, 1998; White, Albers, & Bitoni, 1996), which is always important but even more so in terms of ASFA time limits.

Although all child welfare services are directed toward these purposes, visitation is unique because it is a required service, often mandated through state legislation, and geared toward achievement of safety, permanency, and well-being when a child is in care (Hess, 2005). Visitation offers many benefits. As a primary mechanism for maintaining family contact, visitation promotes healing of the parent/child breach caused by both the maltreatment and the separation, and promotes building or restoring a home through either reunification or another plan. It is unlikely that the desired outcomes could be achieved outside the context of child/parent contact, and without being guided and enhanced by a skilled worker and skilled foster parents. All other services for parents and children who have been separated through out-of-home placement may be coordinated and their results tested through visitation.

The benefits of visitation relate to psychological/emotional readiness for permanency and actual work toward change, and supports appropriate outcomes.

Psychological/Emotional Readiness to Change

Visitation can ease the pain of separation and loss for both parent and child (Littner, 1975). When this pain is repressed rather than recognized and dealt with, it may come out through a variety of symptoms. Visitation also provides ongoing links between child, parent, siblings, and other important figures, thus maintaining and strengthening family relationships and reassuring the child of the parent's well-being.

A mother's motivation to change is enhanced when ongoing contact with the child provides reassurance that she is still the parent and will continue to play a meaningful role in the child's life. Millham, Bullock, Hosie, and Haak (1986) noted that parents can feel disempowered when their children are in care and this can undermine their sense that they can affect their child's life-but visitation can restore some sense of empowerment and support their motivation to change.

Lastly, visitation supports the child's adjustment in the foster home (Hess, 1999; Wolchik, Fenaughty, & Braver, 1996). Children who experience regular visitation show fewer behavior problems (Colon, 1978, as cited in Cantos, Cries, & SHs, 1997), as visits help them cope with their pain and allow the parent to give permission for them to settle into the foster home while the parent works toward reunification or another plan.

Actual Work of Change

The actual work of change occurs and is demonstrated during visitation (Loar, 1998). First, visits help the parent deal with reality (Hess & Proch, 1993). Whatever the mother may say or believe about motivation toward parenting or ability to parent, during visitation she experiences the full effect of dealing with child care issues and challenges along with her own deficits. On the other hand, during visitation she can discover and build on her strengths; learn, practice, and rehearse new behaviors; and demonstrate she is making progress in the areas of parenting related to the reason for placement (Hess, 1998).

Child development does not wait for a permanent plan to be realized but continues throughout placement, and infant development proceeds at a particularly rapid pace. It is important that development proceed within the context of relationship with the birthparent, especially if reunification is an option. During visitation, this continued relationship is assured (Chiancone, 1997). Continuing parental contact is fundamental to the child's sense of self, significance, and identity (Colon, 1978, as cited in Cantos et al., 1997).

Visitation is an ideal setting for ongoing sharing of information among parent, child, and other significant participants. Thus, all participants can keep up with the child's life and the lives of the child's family members. The opportunity for the parent to stay current

with the child's development and activities is particularly important. The child's life goes on while he or she is in care, and it is important that the period of out-of-home care not go on to create a huge gap in the parent's ongoing knowledge of his or her child.

Support Outcomes

Visitation in many ways supports the determination, achievement, and stability of the permanent plan or case outcome. During visitation, the parent has the opportunity for self-assessment, and the agency can assess the potential for reunification. Observing parent and child in a variety of settings clarifies parenting competencies and supports decisionmaking regarding the case plan-whether it can continue as reunification or it must be modified.

If reunification is achieved, visitation can be used to ensure that the transition occurs smoothly. Progressively increasing the frequency and length of visits, decreasing and eliminating supervision, and moving to overnights and extended visits in the parent's home allows for gradual resumption of responsibility and opportunity to identify and resolve problems (Wright, 2001). In addition, it can support family stability, reducing the likelihood of disruption after reunification has occurred (Simms & Bolden, 1991). On the other hand, if reunification is not the plan, visitation can help participants cope with another plan, grieve, and work out their future relationship. Regardless of the case plan, visitation will help the family transition to their new realities (Hess & Proch, 1993; Wright, 2001).

Special Issues in Visitation for Infants with PSE

Visitation involving infants with PSE raises concern not only because of the growing numbers involved, but also because these infants often present special risks and require special care. Although outcomes vary for these infants due to the timing and combination of their PSE, they are at increased risk of special medical and care needs, including developmental delays, premature birth, poor muscle tone, apnea, growth inhibition, and increased rates of Sudden Infant Death Syndrome (Bauer, 1999; Howard, Beckwith, Rodning, & Krospenske, 1989; Ty 1er, Howard, Espinosa, & Doakes, 1997).

Because of neurological damage due to PSE, these infants may be easily overstimulated, have piercing and insistent cries, experience difficulty feeding and being comforted, sleep lightly and irregularly, and be irritable and fussy (Bauer, 1999; Zuckerman, 1993).

Visitation between birthparents and their infants with PSE is exacerbated by the birthparents having the additional stressor of their own substance abuse. These parents are at high risk for child maltreatment for several reasons, including their physical and psychological addictions, their involvement in illegal and dangerous behaviors, and their frequently impaired perceptions (Anderson, Elk, & Andres, 1997; Graze et al., 1994).

Working with Birthparents with Addictions

Because visitation is the primary mechanism for repairing the parent/child relationship and preparing for safe reunification or for transition to another permanent plan, its success is dependent on working closely with birthparents. Yet, when birthparents have addictions, special challenges may exist.

Dealing with inconsistency/relapse. Persons with addictions almost always relapse one or more times and are at risk for having their children placed or replaced in foster care (Dore & Doris, 1997; Potocky & McDonald, 1996). Parents struggling with addictions may be more likely than other parents to be inconsistent in visitation due to relapsing or trying not to relapse. Because visitation is meant to be orderly and planned, missed or late visits will be frustrating. Workers, foster parents, and most especially the children need and want to count on birthparents to be there, and on time, for visits. Birthparents who relapse may be viewed, at best, as being undependable and, at worst, as choosing substances over their children. In fact, it is much more helpful for child welfare workers to learn about addictions and how common, even universal, relapses are in the process of recovery (Groze et al., 1994).

For instance, in Dore and Doris's (1997) study of 138 substance-abusing primary caregivers, less than half (41%) of the 119 participants were able to stay sober for the one-year study period. When workers understand addiction, they may be more effective helpers for birthparents because they can acknowledge the risks of relapse with their clients and work to build in supports and safety plans for when they occur.

Dealing with birthparents' guilt and denial. Denial is a hallmark of addictions. In fact, denial serves a protective and defensive function for persons with addictions. For birthparents, denying their substance abuse can protect them from the guilty knowledge of the effect of the abuse on themselves and their children (Grief & Dreschler, 1993; Kauffman, Dore, & Nelson-Zlupko, 1995).

Because, as previously noted, visitation can provide opportunities for parental change and dealing with reality, both can be impeded by parental denial. Denial may play out as a birthparent's minimization of substance abuse, child maltreatment, or other aspect of the parent's responsibility for the risks that lead to foster care placement. On the other hand, when birthparents with addictions can lower their defensive denial, they may be overwhelmed with guilt. Guilt, too, can challenge the visitation process. Birthparents may feel they are not visiting their child enough and recognize they have harmed the child. Workers may be more effective in facilitating visitation with birthparents with addictions when they are aware of the parents' denial and guilt.

Working with birthparents with impaired parenting behaviors. By definition, if children are in foster care, their parents' behaviors were found to be impaired. Recent research has indicated, however, that birthparents with addictions may present even more difficulties in parenting than do other birthparents, due to lack of knowledge, lack of support, and high stress (Carta, 1997; Dore & Doris, 1997; Williams-Petersen, Myers, Degen, Knisely, Elswick, & Schnoll, 1994). For instance, Kelley (1998) found that birthmothers with addictions were significantly more stressed, more dysfunctional in interactions with their

children, and more distressed in their parental roles than demographically comparable parents without addictions. Other studies have raised similar concerns about parenting behaviors of birthparents with addictions (Camp & Finkelstein, 1997; Chasnoff, 1990).

It is important, therefore, for workers to provide intensive parenting training and support programs when planning visitation interaction with birthparents with addictions. For instance, Black, Nair, Kight, Wachtel, Roby, and Schuler (1994) and Hofkosh, Pringle, Wald, Switala, Hinderliter, and Hamel (1995) have described two intensive education/early intervention programs for drug-abusing women and their children that resulted in some increased outcomes for both mothers and babies. Dore and Doris (1997) also noted the importance of parent education with this population.

Meeting established time frames. Another challenge in facilitating visitation with birthparents that have addictions is that addictions are long-term, if not lifelong, and time frames for reunification under ASFA and state laws are short. This means birthparents have great difficulty becoming and staying clean and sober within the typically expected time frame of less than a year for reunification (McCullough, 1991). Of course, child welfare time frames have been shortened intentionally to hasten permanence and meet children's needs, but they create tension with general expectations about addictions-that a year into recovery is still likely to be a fairly "tender" recovery. Workers, therefore, need to work intensively with these clients while their children are in care, while also recognizing some birthparents may not be able to meet established time frames.

Overcoming environmental challenges. Many, if not most birthparents with addictions live in neighborhoods that support their addictions through the availability and acceptance of substance abuse. Maintaining sobriety in an environment that includes many individuals with active addictions is difficult. In addition, as these neighborhoods tend to have high rates of poverty and crime, visitation may be impeded by workers' reasonable hesitation to risk children's safety by having visitation in the parents' own homes (Carta, 1997; Potocky & McDonald, 1996). As Dore and Doris (1997) noted, however, it may be especially difficult for birthparents with addictions to leave relationships with drug-using partners or relatives or to move from drug-ridden environments, because these are their supports. Workers will be more productive when they better understand this, and can work with parents to add other supports and make safety plans.

In summary, these challenges in working with birthparents can compromise the potential benefits of visitation. For example,

* relapses, resulting in inconsistent visitation, frustrate attempts to maintain ongoing links, and undermine the child's reassurance of the parent's well-being and the parent's sense of empowerment in his or her role;

* both denial and guilt can interfere with a parent's motivation to change and his or her ability to learn and demonstrate enhanced parenting skills;

* the stress and distress of birthparents with addictions, along with limited supports, complicate their ability to correct impaired behaviors;

* the long-term nature of addictions makes reunification and subsequent family stability difficult within new shorterterm time frames;

* the neighborhoods where parents with addictions live often complicate an ecological approach to visitation; and

* environmental challenges that threaten sobriety, increase the difficulty of transitioning to reunification and maintaining that outcome.

It is important for workers to have the understanding and skills to confront these challenges.

Working with Foster Parents Around Birthparents with Addictions

A critical component to successful visitation is the involvement and support of foster parents, who must be considered core team members. Foster parents may face some of the challenges noted above for workers, as well as additional challenges in working with birthparents with addictions (Burry, 1999). These may include:

* Dealing with strong feelings about the birthparents having exposed their children to alcohol and/or drugs. Sometimes foster parents, particularly if they are not very knowledgeable about substance abuse, believe that birthparents may have harmed their children intentionally. Because PSE could have been prevented, foster parents may feel justified being angry with or resentful about visitation with birthparents. However, these feelings, if not addressed, can be counterproductive to the goals of visitation. Education about the power of addictions, therefore, is helpful for foster parents of infants with PSE.

* Trust issues. If birthparents with addictions contact foster parents or visit their children inconsistently, foster parents may have difficulty supporting visitation. Although the overriding concern is safety of the children, and foster parents should be prepared to notify workers about problems that occur with birthparents, it is helpful for foster parents to differentiate inconsistencies from actual risks. Again, education about behaviors commonly associated with addiction is helpful.

Teaching Birthparents How to Care for Their Infants with PSE

The central work of visitation involves changing parental behaviors and improving parent/child interactions. As noted, however, infants with PSE may be more difficult to care for than infants without such exposure. Because birthparents with addictions may have less knowledge and fewer parenting skills than other parents, workers may be faced with having the least-prepared birthparents working toward reunification with the most challenging infants. Therefore, it is especially important for birthparents with addictions

to receive special teaching on caring for their babies. Some of the topics to be covered include the steps discussed below.

Being consistent and reliable. Birthparents need to know that, although all babies can benefit from routines, babies with PSE are especially helped by consistent routines. Babies with PSE often have difficulties in self-regulation, that is, being able to meet some of their own comforting needs and moving smoothly from one emotional state to another. This is also known as having poor state control. Babies with poor state control have "yo-yo" moods-going quickly, for instance, from a very happy state to a very miserable state without an intervening period of increasing fussiness. Being consistent and reliable in caregiving promotes attachment and supports the development of self-regulation in a baby with PSE (Carta, 1997; Hofkosh et al., 1995).

Learning to read the baby's signals about stimulation. Because of guilt or well-meaning attempts to make up for the PSE, birthparents may be overstimulating their babies (Kronstadt, 1991). For instance, they may purchase brightly colored musical toys for their babies' cribs without realizing they are overwhelming their babies with stimulation. Instead, birthparents can be taught to read their babies' signals about their readiness for play or other stimulation. When a baby is ready for stimulation, he or she may yawn, sneeze, hiccup, look away, or stiffen. When babies indicate readiness to be involved, birthparents can be taught to work with one sensory pathway at a time. They can use visual stimulation by showing a picture book, use auditory stimulation by singing or playing a CD, or use kinesthetic stimulation by quietly massaging the babies' limbs.

Responding quickly to their babies. Birthparents of babies with PSE, like other parents, may worry they'll spoil their babies with too much or too quick responsiveness to crying or fussing. But these birthparents can learn that meeting babies' needs, whether for food, diaper changes, or attention, is never spoiling them-in-stead, it is nurturing them and fostering attachment. If babies cannot attach strongly, either because of their impairments from the prenatal exposure or because their birthparents don't respond appropriately, they are at risk for future developmental and relationship problems (Kronstadt, 1991). In particular, babies with PSE exposure may have lowered abilities to delay gratification and should be attended to promptly. Responding quickly can also lessen the likelihood of a baby with poor state control moving to an intensely upset emotional state.

Letting other caregivers know what works with their babies. During visitation, birthparents should gain expertise about what works with their babies. They should move toward becoming the experts on their children. As they gain confidence and competence in caring for their babies, they should be taught that others who care for their babies should also be given this information. For instance, if a birthmother will be using a day-care center for her baby after reunification, she needs to talk with the staff about her baby's special needs, if any, and about the strategies she has found to be most helpful in calming her child.

Decisionmaking Around Permanency

We have seen that when birthmothers use drugs during pregnancy, their infants with PSE will likely be placed in foster care. The special needs and care requirements of these children, in combination with the stress caused by substance abuse, brings into question the capacity and ability of drug-using birthparents to care for their PSE infants. Moreover, ASFA imposes time limitations for permanency planning that can be challenging to meet when substance abuse is involved.

In making decisions regarding permanency planning, the stakes are high. Although substance use or abuse alone is not a sufficient reason for termination of parental rights, it is a very serious factor in terms of assessing a birthparenf s ability to care for an infant and ensuring the child's safety, permanence, and well-being. Thus, decisionmaking regarding the permanent plan is an important purpose of visitation. But decisionmaking can be complicated by the increased use of different arrangements between children and parents and different case goals other than reunification and traditional adoption, such as formal and informal kinship care, guardianship, open adoption, and long-term foster care. Lastly, the practice of concurrent planning-when it is understood from a placement's beginning that the case goal (permanent plan) can change during treatment-emphasizes the utility of visitation in determining the most appropriate goal.

Even the best permanent plan requires decisionmaking, possible adjustments and changes, and achievement-and all these steps are supported by good monitoring. Monitoring is important particularly in terms of ASFA timelines, because participants need to know how they are doing so they can address any obstacles immediately. Failure to monitor adequately can leave families facing time limits without having made sufficient progress and without the opportunity for correction. Ideally, revisions in the plan can be made to better accommodate the family and to reveal when "reasonable efforts" are insufficient to achieve one permanency goal and another goal must be considered.

In terms of working with substance-abusing birthparents, conditions for reunification should be clearly defined. Because we are so guarded in assessing such parents, and with good reason, it is imperative that issues be framed in terms of parenting ability and child safety rather than the single fact of substance abuse. Thus, several questions take on great importance. These questions need to be explored by monitoring visitation and the decisions made based on answers to the questions as determined by the team of foster parents, child welfare workers, addictions counselors, and anyone else involved in treatment and visitation. These questions are:

* Has the birthparent dealt with denial and faced reality about the effect of substance abuse on himself or herself and the child? This is absolutely necessary to ask for the child welfare worker to have any confidence in the parent's ability to keep the child safe.

* Has the birthparent learned and demonstrated the parenting behaviors that meet the special needs of the PSE infant? Has the birthparent demonstrated during visitation that he or she can and will adequately care for the infant independently, without the supervision of the foster parent or other person?

* How consistently can he or she parent? In light of our knowledge about relapses, what can we predict about this birthparent's relapses and their effect of these on child safety? What did we learn about relapses during visitation? Did they result in inconsistent visitation, and will they also result in inconsistent parenting? How did the birthparent handle relapses? Does the birthparent live in a neighborhood that makes relapses almost a certainty?

* How stable is the recovery? In making the decision to reunify, we need not only a snapshot view of recovery, but also some expectation that it will continue. How fragile is the recovery, and how could this affect the child's safety?

* What supports are available and reliable to see the birthparent through relapse? Have relatives or other reliable resources demonstrated during the treatment period that they can and will step in to ensure child safety during periods of relapse and parental instability?

Conclusion

Permanency planning for infants with PSE is challenging due to characteristics of the infants and the ongoing use or relapses of the parents. Though substance use is a critical issue in planning, it cannot be the deciding factor in decisionmaking about permanency. The child welfare service of visitation is the primary mechanism through which workers normally deal with issues such as psychological or emotional reactions to separation, improvement of parenting skills, sharing information, and determining and supporting permanency planning. Visitation is no less important when substances are involved. Productive use of visitation for permanency planning, however, depends on workers understanding how substance use affects the dynamics of visitation and skillfully focusing visits on issues and needs that are particularly relevant to this population.

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[Author Affiliation]

Caroline Long Burry PhD MSW is an Associate Professor in the School of Social Work at the University of Maryland-Baltimore, Baltimore, Maryland. Lois Wright MSSW EdD is Director of Evaluation and Education, School of Social Work/Virginia Institute for Social Services Training Activities (VlSSTA), Virginia Commonwealth University, Richmond, Virginia.
Address reprint realuests to Caroline L. Burry, University of Maryland, School of Social

Work, 525 West Redwood Street, Baltimore, MD 21201; E-mail: cburry@ssw.umaryland.edu.